THE STRANGE CASE OF THE MISPLACED SUPPOSITORY

Caroline Richmond

In Brief • En bref

In a controversial decision, the General Medical Council has found a consultant anesthetist guilty of serious professional misconduct for giving a painkilling suppository without forewarning the patient and obtaining consent. Even though the suppository was misplaced in the patient's vagina, this was accepted as a mistake; at issue was whether a specific separate consent was required for insertion of the suppository.

Dans une décision controversée, le Conseil médical général a jugé un anesthésiste-conseil coupable d'inconduite professionnelle grave pour avoir administré un suppositoire analgésique sans avoir prévenu la patiente ni obtenu son consentement. Même si le suppositoire a été introduit par erreur dans le vagin de la patiente, on a accepté qu'il s'agissait d'une erreur. La question était de savoir si l'anesthésiste devait obtenir un consentement distinct précis pour introduire le suppositoire.

In its most controversial decision in years, the General Medical Council (GMC) in Great Britain has found a consultant anesthetist guilty of serious professional misconduct for giving a painkilling suppository without forewarning the patient and obtaining consent. The patient was having four teeth extracted at a dentist's office. The doctor, in his 40s and a consultant for 10 years, mistakenly put the suppository in her vagina.

The hearing, the decision and the subsequent debate accepted that the misplacement was a mistake and that no attempt at sexual molestation was involved, but the anesthetist was found guilty of serious professional misconduct and admonished.

Anesthetists are angry about the decision, arguing that ethics and protocol should not have to distinguish between different parts of the anesthetic procedure and that the same rules should apply regardless of whether the patient is in an operating theatre, a day-care ward or a dentist's office.

The facts of the case were accepted by all parties. The woman went to the dentist to have four teeth removed from her lower jaw. While she was unconscious, the anesthetist loosened her clothing and inserted a diclofenac suppository. He did this in the presence of the dentist, who was male, and two surgery assistants, both female. He had not discussed pain relief with the patient beforehand, but as was his usual practice he told her and her husband about the suppository when she was in the recovery room afterwards. Some while later she noticed discharge from her vagina and went to the police. They investigated and rapidly concluded that the case did not involve a sexual assault.

At the GMC hearing the issue was whether a specific separate consent was required for insertion of the suppository. The anesthetist argued that his actions were part and parcel of the general anesthetic and were covered by the patient's consent to this. He had simply tried to maintain the same standard of anesthesia, including pain relief, in the dental surgery as in the hospital.

Several senior anesthetists testified on his behalf. None had given a suppository in a dental surgery, but agreed that in many hospitals it was not deemed necessary to obtain specific consent to use a diclofenac suppository. Also, giving a suppository was not inherently different from giving an injection, which is often given in the buttocks and requires undergarments to be disturbed.

The GMC called experts who said that specific consent was always obtained when suppositories were given in day-care units, and often from inpatients. They also drew a distinction between suppositories and intramuscular injections and, in particular, drew attention to the differences between the expectations of a patient who went to her local dentist and one who was in hospital.

John Mitchell, a London lawyer, recorded the case in the *British Medical Journal* (A fundamental problem of consent; 310: 43–46). He accepted that use of the suppository was such a departure from what the patient might have expected that it should have been explained to her in advance. But he expressed alarm at the logical conclusion to this: that the committee found that in insert-

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— Dr. Graham Ness

ing the suppository, the anesthetist had assaulted the patient. Mitchell sees this as leading to an increase in the amount of defensive medicine, with possible damage to patients' rights to the most effective treatment reasonably available.

A professor of medical law and an anesthetist added their comments to Mitchell's article. Michael Jones of the University of Liverpool's Faculty of Law pointed out that the case was properly treated as a matter of assault, not negligence. Therefore, it is irrelevant whether a thousand anesthetists would have administered the suppository without specific consent: the requirement to obtain consent was imposed by the law. "Patients are entitled to know in broad terms what is going to be done to them, and it will no longer be possible, if it ever was, to rely on a signed consent form as a 'consent to anything that may happen to me.' "

He added that it would be a pity if the case was used as a reason to act defensively; instead, he said it should be used as a reason to enter into a genuine dialogue with patients.

A university reader in anesthetics, Dr. John Lunn of the University of Wales, disagreed. He recognized the affront to the patient but felt the verdict was extreme, given the anesthetist's benign intent. Although it is impracticable to give the patient a recital of all the drugs to be used, together with their routes of administration and possibly the machines used for delivery, he would personally, while describing beforehand what he would do, have included: "You will be given a painkilling suppository which will help numb the pain afterwards." He concluded that "it seems to me that this entire case was provocative at first, meddlesome in the middle, and outrageous at the end."

Needless to say, the three *BMJ* articles attracted a wide range of correspondence, much of it from nervous anesthetists. The president and secretary of the Association of Anaesthetists of Great Britain and Ireland wrote that there is nothing essentially remiss in present methods of gaining consent, and that "sectionalised consent" (to various aspects of the anesthetic procedure) was unnecessary. Nevertheless, they emphasized, it is both polite and prudent to give details that may be unfamiliar to the patient, such as information about the potential use of a suppository.

Professor Felicity Reynolds of St. Thomas's Hospital and Colm Lanigan of Lewisham Hospital thought the GMC's decision "ill informed," and suggested that many anesthetists of good standing might be deemed guilty of serious professional misconduct under the ruling.

Reynolds, a retired professor of anesthesia from the University of Wales, reminded *BMJ* readers that this was an accidental vaginal placement — "this was called a 'trivial if easily explicable error' but it calls into question the competence of the operator. Few patients, if counselled that they would be given a suppository, would consent to a suppository that might result in accidental vaginal placement with resulting signs."

Two sets of respondents did some quick research among their patients. Almost all patients would expect to be forewarned about a suppository and over half would have declined; two-thirds would prefer to take the painkiller orally.

And the last word must come from a general practitioner, Graham Ness, who wrote from the psychiatry department of St. James's Hospital in Leeds: "Many doctors seem quickly to forget that vaginal and rectal examinations are particularly intimate. This is because they may have many such procedures to carry out and they find the associated feelings of intimacy uncomfortable. This makes them anxious. A way of dealing with this is to 'forget.' There is, however, an inherent disadvantage: these doctors will lose touch with the feelings of the people for whom they care. This is the brutalizing effect of medicine. Exposure of private parts makes a woman vulnerable, so to expose herself to someone else is an act of trust and therefore generates intimacy. This trust must be respected and the intimacy acknowledged."

Amen. ■

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